System Transformation Initiative/Fall Community Forum

MEDICAID BENEFIT PACKAGE

1. WHAT SERVICES AND SUPPORTS ARE MOST HELPFUL FOR PEOPLE IN THEIR RECOVERY?

Table Notes:

- Early identification of specialized services for seniors
- Early identification of specialized services for children
- Access to medications early on
- Services that support people *before* institution, nursing home, jail, JRA
- Family/caregiver support and involvement
- Early assessment and screening involving family/support systems
- Helpful to have Medicaid paying co-pays/out of pocket Medicare D
- Jobs (sense of need for patient)
- Self-directed care
- Access to follow-up care
- Access to pharmacy
- Opportunity to substance abuse services in/out
- Increased funding, quicker process to access $
- Formalized peer support system
- Economic independence
- Age appropriate support and activities
- Multiple work models
- Housing well integrated into community—using neighborhood marketing
- One stop shop includes medical, social, meals, activities
- Community education to reduce stigma
- Support individuals in gaining insight
- Education for consumers/families media and systems
- Medication management to people in community
- Emphasis on holistic medical care. ARNP
- Getting consumers on right medication
- Timely interventions and continuity of care/full array of care
- Somewhere decent to live and something meaningful to do
- Continuum of services, inpatient and sequential step downs to OP; include all steps with a continuum
- Transitional planning and support from intense care back into community, psychiatric and criminal justice
- A true beacon of hope--use of peer support
- Safe and comfortable environment with meaningful activities
- Health education with patient and families
- Holistic approach for all issues: medical, chemical dependency, psychiatric
- One stop care home with financial support
- Money follows the person

- Safe, affordable, supporting housing
- Available housing
- Living stipend for short term to establish housing
- A continuum of recovery support
- House for chronic mentally ill and medically fragile
- Co-occurring treatment options
- Gero-pscyh
- Medication management and observation
- Peer counseling
- Day support, drop-in center and peer support
- Stabilization services: crisis services, medication management, inpatient treatment, case management
- Recovery Services: supported housing (on-site 24/7), stabilization services (clubhouse, group treatment), skills training (social skills, vocational skills), peer support (giving and taking it), seeing a therapist, supported employment, outreach oriented services
- Interventions in natural settings leads to decreased: hospitalization, respite, crisis, meds
- Pure case management system helps client navigate the system and resources
- Increased patient education about diagnosis, prognosis, treatment and symptoms
- Flexibility in service delivery
- Access to psychiatric care and medication, i.e., drop-in center can access services/scripts
- Better transitional services with resources
- Respite services/crisis bed available
- Identifying barriers for hard-to-reach consumers--transportation, stigma, trauma of intake, access, i.e., outreach access to care, understanding barriers, and identifying barriers and coordinate efforts to over come. Ideal develop one stop shopping for mentally ill with criminal history
- Access to system—applying for SSI, Medicaid, etc; professionals may not know how to make it happen for clients
- Most helpful: outreach, activities decreasing isolation
- Peer support program (check with Pierce County)
- Housing, individually tailored services
- Creative outlets—garden planting, making baby blankets
- Making pet ownership part of therapy if requested
- Consumer driven choice
- Barriers: decline of number of beds in community-based hospitals—waiting emergency or consumers end up going to hospitals when, for example, what they need is intermediary detox, etc.
- Barriers: homeless—drug and alcohol—no place to live, go
- Barriers: cross-over of diagnosis: ex mentally ill and ADD, etc., secondary diagnosis overlooked and creating barriers to treatment
- Comment: DOC need intermediary to secure benefits for clients
- Access to treatment on demand for dual diagnosis people
- Access to treatment on demand for people with any co-existing conditions
- Services for sub-acute conditions

- Community education and outreach regarding older adult adjustment and sub-acute conditions
- Partial hospitalization options
- Consumer-directed treatment built upon individual goals that includes an infrastructural based self-management approach
- A preventive health care model including primary care integration
- User-friendly access to service options
- Case management, intensive PACT teams, reasonable caseloads
- Appropriate employment; attitude of hope
- Hope-centered, peer to peer, [table six highlight] help desired services by consumer, consumer choice, money follows consumer
- Empowerment and choice—choice of psychiatrist with EBP, case management, follow-up and medication adherence
- Peer counselor—reality discussion and support in community, non medically based, kindness, relationship respect
- Grief counseling—loss with a spiritual component, partnership with out patient/inpatient services with case management
- Decreased crisis management, community mental health partner with hospital
- Patient goal oriented, wellness model
- Peer support available 24/7, there are hidden rich services, crisis is short term
- Progressive advocacy—advocacy to the degree needed
- Giving/receiving peer support
- Housing
- Social supports
- Club house
- Structure to day
- Housing with supported services onsite
- Medication monitoring
- Accessible asylum (respite)
- Flexible respite care
- Access to services for sex offenders with a mental illness
- Timely services
- Quality time with clinicians
- Client-constructed services
- Medication management, especially for children
- Peer support services
- Education for family members
- Ability to build relationships with clients
- 1290 forums
- Get to the families early, understanding the system
- Early care, GAU medical, information and support
- Education/supportive education vital
- Too much delay in information
- Having consistent staff involved with individuals
- Experienced clinicians well paid rather than divide money up among a lot of small positions

- More professional and peer partnership
- Parent to parent supports
- Aging system is stressed by aging mental health population. Fund more mental health programs for mentally ill adults
- More intensive services that are not as time limited
- More in home services, family, work for adolescents
- More ECS slots
- More PALS like programs local instead of at hospital
- Patient education
- Identification of when people have reached their maximum functioning instead of creating failure
- For youth and family: Connectivity to the broader community (church, social organization, other families) external to the CMHA
- For youth and family: Grass roots networks—other parents and youth
- For youth and family: youth and family support including family care givers
- For youth and family: wrap about with fidelity—national wraparound initiative
- Problem: most people 1/3 on up starting to get better, TXIX gets cut
- Peer support, clubhouses, housing, essentially services Medicaid agency providing to the TXIX client who is more ill
- Programs are culturally competent, linguistically, so consumers have access to services out there
- Critical for all populations, education is key, for consumers
- Chemical dependency services, case management, housing stabilization services are critical, especially, housing, a job and a friend—still critical
- Stable housing, support getting jobs and support/peer network
- Yes—crisis treatment is critical and preventative
- Employment services, especially with long term support of employed people
- Housing for homeless, services for homeless
- Quick intake into social security
- Peer support services
- Jail services
- Discharge planning before released from jail
- Ombuds protection of consumer rights
- Cooperation between chemical dependency and mental health services
- Services planned especially for Russian, SE Asian and Spanish speaking people

Summary Notes:

- Age appropriate regardless of disability
- Infrastructure
- No fragmented care
- Education for community, family, individuals
- Housing services to support people in getting housing to be stabilized and participate maintaining in other
- Contribution to their community being facilitated—education for kids, employment for adults, meaningful activities

- Flexibility in benefits package—allows services to be tailored to individuals with cultural needs and people to be hired and retained to deliver those services
- Housing for the homeless
- Ombuds services—so people keep their rights
- Federal government's minimum turnaround time for social security is two years. None of the transformation processes address the Federal government's slow social security eligibility process
- Put employment early in the recovery process. Employment is central to recovery
- Peer support counselors
- Early outreach, screening, assessment, medications and treatment services
- Specialized outreach services for specific populations, at earliest possible point
- Outreach, including involvement of family/supports
- Employment; economic independence
- Access to pharmacy
- Self-directed care
- Gero-psych units
- Medication management and observation
- Peer support, day support, drop-in center and peer counseling
- Peer support
- Outreach and community-based engagement, for non-compliant consumers or those that do not have transportation
- Informed prescribers
- Access to care needs to be easier for consumers and families
- There needs to be more coordination of services—to better "treat" people with mental illness and other problems
- If mental health and primary care worked more closely—preventive services could be provided (reach out to address mental health needs)
- Partial hospitalization programs
- Clubhouses. Drop-in services. Advanced directives help people take responsibility for their own care. WRAP planning group
- Access to all care: general health, substance abuse, as well as mental/behavioral health care, dental
- Integrated services
- Community coordinated approach for feeding and homelessness
- Keeping churches involved
- Communication method/forum in community to maximize use of resources
- Training non-professional providers
- On-site mental health housing services
- PALS in the community
- Reasonable case loads
- Empowerment and choice
- Housing and medications
- Peer support
- Housing
- Medications and monitoring
- Timely access to care

- Early education and information and support to families and other caregivers
- Expanded community services funds
- Peer to professional/family to family
- Comprehensive continuum of service that meet person's identified need at whatever stage of recover/resiliency they are at
- Collaboration
- Peer support and education
- For children, youth and family: connectivity to the broader community (church, social organization, other families, schools, etc.)
- For children, youth and family: Grassroots networks—ensuring access to other families and youth
- For children, youth and family: Wraparound services with fidelity to the national wraparound initiative—family central

Individual Questionnaires:

- For kids and youth: supported housing
- For kids and youth: social supports
- For kids and youth: advocacy from grassroots organizations
- For kids and youth: To realize that it may not be recovery you are working on but maintenance
- Case management
- Chemical
- Has stabilization
- Housing, job, friend
- Housing, housing
- Employment
- Peer support/social rehabilitation
- Access to house, job, friend
- Supported education leading to gainful supported employment
- Peer counselors—promote services to consumers—utilized in authentic PC support services—increase recovery implementation/principles in curriculum
- WRAP to ensure families are supported
- Ombuds to ensure families are supported
- Co-occurring peer support promotion delivery of services
- Early identification
- Access to medications
- Outreach, evaluation and treatment
- Family caregiver
- Specialized outreach, evaluation, case management, treatment services, eg. For aged, children in most accommodating setting, eg., home, school, etc.
- Early identification, maintenance of independence
- Family—caregiver involvement and support in all aspects of identification, evaluation and treatment
- Decent housing
- Meaningful work and activities

- Respect and age appropriate
- Continuity of care/wraparound services
- Timely interventions
- Education/training
- Housing in a safe and friendly environment
- Something meaningful to do on a daily basis
- Putting more funding into therapy—less into other services
- Drop-in centers engages people—clubhouses give life
- Appropriate referrals and access "in a timely manner"
- Treated as a person first; offering choices
- Client-centered system response—linkages
- Coordinated service among various providers
- Outreach/engagement and help to navigate system
- One stop
- Peer support/coach/advocate/family support
- A team approach
- Programs to treat dual disorders
- Partial hospitalization
- Early education
- Housing with peer support on site 24/7
- Case manager
- Giving and receiving peer support services
- Supported education and supported employment
- Supported housing and/or housing supports
- Education in behavioral interventions and crisis management skills
- Social supports—a place to go—clubhouse, drop-in, support group, etc.
- Individual supports
- Integrated treatment relationships that make sense of substance abuse, mental health, housing, law enforcement/police system
- Dual diagnosis
- 1290 DSHS
- Housing with supportive services on site
- Medication monitoring
- Skills training re: self-medication
- Accessible "asylum" from stressors as needed
- Quality time with clinicians that build therapeutic relationships
- Peer support services
- Education for family members
- Medication management, esp. for children
- Timely services
- Sufficient time with case manager
- Client-centered, client directed services
- Housing
- Clubhouses
- Individualized services
- Early intervention—early education of parents/family

- Good case managers
- Housing: low income
- Nursing services as part of residential care for the elderly and disabled
- Supports: Increase salary for direct service staff (bad salary leads to increased attrition and results in decreased quality of care)
- Accessible outpatient psychiatric services—plentiful
- Caregiver respite—ongoing case aids
- Intensive family education/support early on
- Increase adult focus when designing child interventions
- Education/training
- Employment/clubhouse
- Individual treatment with a recover focus/client driven
- Peer support/mentoring/parent partners
- Family/natural support building
- Employment
- Wellness education, family education, supported education
- Wraparound services
- Skills training
- Peer support
- WRAP
- Consumer-run
- Peer support—free standing networks (consumer-run)
- Brokerages—choice in home money are spent by “consumer”
- Guide to services (map)
- Housing alternatives
- Employment training—retraining
- Options for alternative treatment—acupuncture
- True self determination—allow people to make mistakes and learn from them
- Peer support
- Clinicians that understand and embrace recovery principles in their practices
- Effective medicines so that people will stay compliant
- Brokerage systems
- Empowerment training for consumers
- Trauma informed services
- Respite—varied; crisis prevention
- Transition age services and supports (see SAMHSA)
- Parent partners—consumer run programs! (Peer support, information and referral, WRAP)
- Choice based on individual need, preference and culture
- Education regarding self help strategies for parents/families
- Intensive in-home services/supports for kids and families (individualized)
- Appreciative inquiry
- Social supports
- Wraparound process
- Youth mentors/youth peer to peer
- Holistic opportunities

- Advocacy opportunities
- Attending support groups
- Socialization opportunities
- Local community connections
- Peer support
- Youth mentors
- Advocacy opportunities
- Training/education
- Brokerages: support, deficit cards, clinicians that embrace recovery
- Respite/crisis intervention skills training
- Employment with supported housing
- WRAP services
- Effective medications
- Self-determination
- Parent partners—giving and receiving; youth to youth
- FFT and DBT
- Education for family members
- Support groups
- Day treatment for children
- Respite care—intensive in home services to include case aides and planned respite for children prior to "all" residential care placement
- Wraparound—high fidelity—strengths based—solution driven planning
- Self-determination/advocacy
- Peer counselors and peer support
- Early intervention/prevention
- Housing rental assistance
- Mental health court
- Community education
- Advocacy—alternatives to incarceration—community education
- Access to care—PATH Program
- Prevention—early intervention—decreasing need for crisis intervention
- Housing assistance—rent assistance programs—re-entry from incarceration or hospital
- Peer support systems—NAMI—peer counselors assist in follow-up—appointments, etc.
- Clubhouse program
- Employment goals—assistance
- Social connectedness
- Parent partner/youth mentor support
- High fidelity Wraparound process
- CBT/DBT
- Choice/voice
- Family and youth run (owned and operated) resource groups and organizations
- Information from other families with an alike situation
- Local advocacy groups—grassroots advocacy—family run organizations
- Individual peer support of young individuals

- Self-directed—consumer driven
- Peer support and WRAP modality training
- What is medical about
- Identifying and eliminate the barriers—i.e., stigma and acceptance
- Coordinating efforts—one stop shop
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2. WHAT SERVICES AND SUPPORTS ARE NOT SUPPORTIVE OF RECOVERY?

Table Notes:

- Services defined by financing services; not defined by needs but by eligibility (not title XIX eligible, etc.)
- Other complication factors: hard to navigate system—how we've structured things is problematic for pt. population and trying to get help.
- Lac of affordable housing available to cts. w/ disabilities.
- Stigma
- DVR & jobs is an issue: order of selection is a problem: clients further toward recovery not even eligible.
- Illness-oriented system contradicts recovery.
- Federal mandates counter to what we want to do in WA (i.e. DVR order of selection, etc.)
- CMS fund vs. not funded may differ
- State ACS is only as funds allow after crisis services met.
- Response to over use of state hospitals
    - Driver is cost-containment at state hospitals with NO recovery for consumers; fall through the cracks…gaps in the system.

- Flexibility: package allows for money to be spent in way person in need wants it to be.
- RE: SDC or MFP: hard to manage system being able to accomplish it.
- What is our goal? Clients getting to direct their own care but not being able to as system is not set up to do that.
- Clients are not educated as where they can go, especially cultural issues—barriers are that they simply don't get the services.
- Tribal care issues are improving funding for those systems
    - Even crisis system is not prepared to take on language barriers.
- Spend downs
- Losing services when someone is employed
- CSO's
- CMHA's don't understand peer-support services—they need training.
- Restrictive eligibility
- Cost of medications
- Lack of housing; supported employment
- Non-specialized services that do not address specific services such as older adults & children.

- Not enough funding for services
- Lack of services that specialize in populations such as children & older adults.
- State has a responsibility for services for non-Medicaid
- Stop-gaps that don't cover meds and services or exclude mental health care
- When employed, many benefits stop—afraid to take risk
- Staff who just "don't get it."
- Day support
- E&T's
- Individual treatment (not self-directed)
- Ghettoizing clients to CCFs/ARTFs/SROs
- Focus on inpatient care not treatment
- Lack of employment and width of employment choices
- Inpatient stabilization does not help because too short a stay
- Lack of continuity between inpatient and outpatient care
- Lack of factual data
- Increased use of crisis services
- Convoluted funding systems
- Access to care standards don't support recovery
- Not sufficient crisis beds
- Silo=difficulty collaborating w/ other reliant systems…DDD, law-enforcement, D/A, DSHS, education.
- Silo funding also decreases ability to collaborate or meet client needs
- Forcing dx to drive funding
- Funding decreased during recovery to fast (SSI, Medicaid, coupons, food stamps, or d/c of benefits too early and no tiering it to individual needs.
- Lack of coordination among tx providers especially regarding med management.
- Care-taking approach of system
- Loss of essential services as persons moves forward in recovery (i.e. medication benefit)
- Medical model integrated w/ recovery model
- Separation of mental health from health care in funding streams
- Never ending LRA
- Illness based
- Not appropriate or individualized
- Round peg in square hole…cookie cutter
- Forced tx
- Non-holistic approach—leaving out medical substance
- Choice that are not choices
- Paternalistic model
- Traditional cookie-cutter treatment needs to be individualized
- Service provider and funded goals rather than including peer
- Frequent/ongoing medication management
- Limited model of continuation for the tx
- Changing meds w/o permission for ct. and
- Group therapy vs. individual therapy.
- Mental health services protective payee

- Housing program that kick out relapsing clients
- Hosing that does not take sex offenders
- Individual services w/ children w/o family involvement
- Referring people to existing programs that are not appropriate because they are what is available—misuse of EBPs
- Forced tx
- Administrators, agency directors, clinicians who do not embrace recovery
- Entire community being educated about recovery and resiliency, eliminating stigma
- Lack of cultural competency among providers
- Justice system does not help people (criminal record can prevent people from getting housing & jobs)
- Too much reliance on hospital & institutional services
- Families having to relinquish custody in order to afford help
- Guardianship for adults
- Professionals who don't get it , the family/youth experience
- Too much focus on the MH & behavioral issues and not on a strengths perspective
- Wrap around that is professionally-driven, not family driven
- Talk therapy for neurobiological disorders

Summary Notes:

- Focus on Crisis system
- Employment and permanent & supportive housing
- Services either lacking completely or insufficient
- Mental health centers aren't really using Peer Counselors s intended, keeping them as file clerks and to Xerox, need mental health center training on how to really use Peer counselors
- Spend downs, some people have $2000 spend down every 6 months and can miss up to 3 months of medications
- Housing services when someone is employed full time
- More support for homeless people
- Intermittent eligibility and service delivery
- Non-Medicaid services and coverage
- General non-specialized services, provider expertise and service delivery (kids, adults, older adults)
- Day Support
- E&T
- Individual treatment (not self directed)
- Getto-izng clients in CCF's and SRO's
- Access to care standards don't support recovery
- Convoluted funding streams, Medicaid is the driver
- Increased us of crisis service due to lack of a stable system
- Segmented systems, lack of collaboration between MH/law enforcement/ancillary programs
- Treatment that is not consumer driven/forced treatment

- Categorizing Care, lack of care for dual diagnosis
- Lack of integration between primary care and mental health care and other systems that serve the mentally ill
- Providers do not work with consumers if they, they treat them like children
- Discontinuance of Medicaid coverage during incarceration and then trying to get it restarted on release
- Starting and Stopping of services with funding changes due to lack of non-Medicaid funding
- Discontinuation of services by "choice" at a time of greatest need
- Supported employment is a low priority, this is a mistake
- Illness/disease based approach, paternalistic
- Non-holistic approach
- Lack of understanding, kindness and personal respect
- Traditional cookie cutter treatment
- Service provider goals vs. consumer goals
- Limited models of intervention
- Referring individuals to existing programs like "EBP's" that are not appropriate when there is "nothing else" to serve the person'
- Individual therapy for kids without family involvement
- Misunderstanding of an EBP or modifying it so that it is no longer effective
- MH Professionals who don't get it, don't understand the experience of families, youth and children
- Too much focus on the symptoms or behavior and not enough supports for strengths
- Talk therapy for individuals with neurological disorders

Individual Questionnaires:

- Forced treatment
- Lack of care for those labeled DMIO
- RSN Wraparound – when professionals protect budget first
- Voc. Rehab needs
- RSN wraparound – when professional protect their budget first
- Voc Rehab needs to be re-worked
- Crisis not whole process-wellness
- 24/7 Services
- Silo of ?
- Improve & lose eligibility… for FWICS
- Crisis emphasis
- "Generalized" & timeline TMT planning
- Individual child /youth TMT w/o family TMT (counseling)
- DCFS mandatory funding CD only or MH only services
- Office "only" delivery of services-forcing individuals out of frame w/o awareness or difficulty for tease of agoraphobia
- Spend down programs
- Once employed consumer needs

- Opportunity to gain footing
- Generalized delivery
- Insufficient funds
- Medicaid funding
- Includes to many aged children – Special state funding needed
- Insufficient financial resources
- Using jail in lieu of hospitalization
- Alternative treatments
- A deficit – based approach to care
- Stereotypes-Limits-Restrictions
- Not recognizing, treating co-occurring disorders or failure to respond
- Lack of integration of medical (even psychiatry) and recovery model
- Integration of the patients to be involved in their transition back to the community
- More club houses
- Crisis housing
- "Choices" that aren't real -ie: lose-lose choices from consumer's perspective
- Affordable medication 24 hour access
- The current size of caseloads case managers have
- Traditional cookie cutter treatments
- Refusing to listen to consumer's perspective
- That have prejudice about different offenses
- Sex offences & violent
- Not listening to client
- Services provider and funder-imposed goals
- Obstacles to face, as needed ongoing med adjustment
- Redundant paperwork
- A client having to repeat their story to more than one case manager in a years time
- Group therapy where individual treatment may be warranted
- Treating people like cattle
- Movement of case mangers because of to low pay
- To much use of jail
- Limits of the tiers: hard to move between tiers & on & off ECS
- Individual therapy with children
- Wraparound services that aren't comprehensive enough and administered in a routine way
- Intensive mental health services delivered by inexperienced "new" providers who are supervised by individuals with little training/experience in the areas they are supervising.
- Individual services
- Day treatment
- Clinician-driven treatment
- Depends on needs of person at a particular time/stage in recovery process
- Narrow "case management" – needs to be referred
- Access to care choices (lack of)
- Training (education) of case managers
- Restrictive nature of services

- Coercion. Forced treatment does not work—the goal is recovery. It keeps people & the community safe, but it does not foster recovery
- Clinicians who stay distant & detached
- Identifying people by their illness & not supporting the whole goal of the "human" (a life experience)
- Crisis line as is
- Medical model approach (narrow & exclusive
- Long term hospitalization / institutionalization
- Giving up custody to State.
- One size fits all tactics
- Blaming
- Cost Constraints
- Special Population consultant
- Lack of Cultural knowledge & sensitivity & resiliency
- Special population evaluation is not effective/needs improvement
- Lack of cultural competence amongst service providers that supports recovery
- Crisis line as it is now is not adequate.
- Sometimes functional family therapy does not work for all families-because the responsibility is on the family, but some families can't give structure because the need structure.
- Access to care
- Access to care standards
- Crisis mode
- Inconsistent delivery of modalities
- Lack of Benefit
- Resources limiting individual therapy
- Consistent delivery of services across state
- Lack of follow up to evaluate effect of services
- Stopping services-eligibility-when incorrect
- EBP's not culturally relevant
- Access
- Funding
- Appropriate services
- Non self by family diverted
- Made by individuals
- To WAC focused—not focused on the needs of individuals

3. WHAT SERVICES AND SUPPORTS ARE NOT PROVIDED OR ARE MISSING FROM LOCAL MENTAL HEALTH PROGRAMS?

Table Notes:

- Permanent supportive housing
- From perspective of landlords: lack of responsiveness to clients in housing by landlords—not a 9-5 problem, need 24/7 capability to support people in housing and to support landlords

- Better ability to share data
- 24 hrs, go responsive
- Rural areas need more creative…collaboration, trading services, etc
- Re: 24/7 care: evaluation & tx centers need to be statewide—prevents people being placed into jails.
- Simply need PACT or similar individualized case management
- Supportive housing (i.e. lack of housing service in the PACT team)
- No peers on PACT teams—where's the "friend" in the formula
- Mental Health centers need education on how to use peer-support counselors
- Spend-downs too high, way too high.
- Housing services when someone is employed
- No support for any homeless persons once they get housing
- Counties (Clark County is mentioned) who cut off access of Ombuds or case manager when a person goes to jail.
- RSNs who don't provide supported employment
- The lack of cooperation between mental health services & chemical dependency services
- Crisis services are the only service at some locations, need early care
- True integration of care between systems—jail, hospitals, schools, foster care, etc.
- Coordination of mental health services w/ health care lacking
- Lack of non-Medicaid services
- Lack of specialized services for specific pops
- Lack of assessment, outreach
- Dasa services for co-occurring
- The "exit" from services
- Lack of incentive to move clients/disenroll when max benefits achieved
- Coordination of services such as mh/cd/dd/etc.
- Prevent stigma
- Trauma services
- Public education
- Medical services available
- Layers of beau racy to facilitate d/c and access services by hospital & consumer
- No cost conscience for RSN
- No QA or review of RSN
- Money is not always well used, needs to be accountability (i.e. outcome measure)
- Lack of preventive care and no way to assess effectiveness
- Safe affordable and supportive housing
- Available housing
- Living stipend for short-term to establish housing
- A continuum of recovery support
- Housing for chronic Mentally ill and medically fragile
- Co-occurring tx options
- Reimbursement for travel & mileage for outreach could change how billed so outreach cost built-in to direct service rate.
- Have rate increase risk cases that would cover 2 clinicians doing outreach
- Inadequate youth services

- Lack of local beds lack of access
- Not enough access to voc rehab facilities
- Inadequate funding for voc tx
- Output. Mentally ill offenders have no funding to support appropriate tx
- In prison a better transition or step down plan fro mentally ill inmates prior to release
- No incentive for people working together or natural supports
- Full continuum of care—prevention, diversion, sub acute, partial hospitalization
- Geriatric, targeted services (in-home services, outreach & education)
- Lack of expectation and criteria for exit from public sector
- State-wide clubhouse
- State-wide local acute crisis center/ inpt. Beds
- Emergency housing for mental health crisis
- Peer support
- Access to care standards
- Transportation
- DBT availability, social skills training
- New experts open to new approaches and innovative tx
- Invisibility, people not aware, intolerant
- Stable housing
- Not enough OT
- Linkages form service to next 'silos'
- Outreach & engagement services
- Prevention-related programs
- Expectations that CMs can do all services
- Providing funding for housing providers
- Not enough staff
- High staff turnover
- Active engagement
- Intensive system for older adults at risk of needs ADSA placements
- Services to sustain and transition following intensive and specific program or intervention
- Transition for youth from juvenile justice to community
- Holistic medication, acupuncture
- Day tx for children
- Access to care standards for kids
- Recovery-trained clinicians in MHAs and schools
- Trauma informed services (i.e. PTSD services)
- Consumer run brokerages—peer-support
- Respite
- Youth peer counseling certification
- Peer support—beyond the formal
- Peer counseling—family to family
- Transitional services, youth to adulthood (dependency to self-directed)
- Mentoring for youth.

Summary Notes:

- System is not addressing ethnicity and needs to follow through on promises related to this, Russian, Asian, Spanish speaking
- Jail services, See Yakima County Jail services
- A lot of RSN's are not doing supported employment even though it is in the state plan
- More efforts to address homelessness
- Still need more cooperation between MH and CD
- Specialized services and providers with expertise , children, adults, older adults
- Drug/Alcohol tx specifically for individuals experiencing mental illness
- Early outreach, assessment, services for older adults and children and those that end up in Jails, JRA, and Hospitals ect.
- No incentives to dis-enroll clients when they have reached maximum benefit
- Trauma services
- Coordination of medical services, lack of resources to meet medical conditions
- WSH: Labyrinth of layers for discharge planning need a "fast track" process
- Available safe affordable housing
- Co-occurring treatments
- Funding in the mental health system
- Effective wrap around teams tailored to meet consumer needs, individual treatment
- Housing for arsonists, sex offenders, DMIO, felons
- Peer counseling
- Coverage for those who don't qualify for Medicaid
- Navigation of the system
- Intervention programs
- Exit Criteria, there is no expectation that consumers will ever leave the system, this leads to people staying in the system for life
- When consumers want to recover they are threatened with loss of services and medications.
- Expectation could be that discharge will include referral to primary care that is familiar with psychiatric disorders
- Dental and Primary care
- Coordination of court ordered services when someone is on an LRA
- Adequate employment services
- Engagement activities
- Local communities not funded to assess needs for services and systems
- Mental health courts
- Rural transportation
- Linkages with local FQHC's
- Peer support
- Linkages transitions between systems
- Consumer choice in treatment modality
- Outreach and engagement for enrolled and "pre-enrolled"
- Prevention
- Sufficient staffing
- Aging system is stressed by lack of targeted MH services to this population

- Lack of Psychiatric services especially for children
- Home based/school based services that go to the client
- Not enough real peer support for families, youth and children, family to family support
- Need more transitional supports, helping youth move from dependency to self directed
- Mentoring for youth

Individual Questionnaires:

- The ability to get into it : to many complaints
- Eligibility criteria
- Understanding of the disabilities of MH
- Something other than TALK therapy
- Programs structured by finances
- Self directed care?
- Language
- Permanent Supportive housing in flat supply
- Employment insufficient
- Geographic disparities- rural
- Cross system referrals through staff awareness of local community resources
- Agencies are not providing " overwhelmed" individuals assistance in accessing services/ determining eligibility
- Ongoing support so that consumer not "made" unstable by starting and stopping Meds.
- Holistic approach
- Jail Mental health service provision
- For the most part all of these are mentioned above
- In number one are missing for special populations
- Coordination in long term care system
- Schools
- Integrated crisis triage
- Peer counseling
- Socialization & connection with wider community
- Administration – high caseloads
- Adequate access to therapists
- Adequate voc. Services
- Peer counseling
- Incentives for community –based care, rather than facility based. (transportation time not counted or reimbursed
- Intensive support team wrap-around that meets the individual consumer needs
- Community based resources that are appropriate
- Housing for arsonists, sex offenders, DMIO
- Peer counseling / ombudsman
- Club houses not present at many of the RSN's
- Lack of geriatric programs (outreach, education, out patient) Geriatric Regional Assessment teams

- Emergency housing mental health crisis
- Partial hospitalization programs (CMS guidelines)
- Lack of self-care focus. No focus on exit criteria
- Programs for dual disorders especially inpatient
- Community education outreach for older adults
- Partial hospitalization.
- Occupational therapy
- Stable housing that is flexible & tolerant
- Neuropsychiatry services
- Outreach & engagement
- Preventative related services
- Pre-enrolment case friendly
- SO & violent client
- Eclectic case managers and or the acknowledgement that CM need to be experts in brokering services to meet many types of human need
- Funding for non-profit housing providers for on-site services for CMO
- Outreach / engagement services
- Insufficient #'s of staff creates a barrier to effective, timely access to services
- Active engagement pre-enrollment i.p. case finding
- Housing for MH consumers which tolerate relapse on CD
- Connections between MI friendships mode and then they are moved to another place & never found again
- Not enough occupational supports
- Far too poor pay scale to keep staff.
- Should be equal to teachers for example. Should have retirement benefits.
- Residential facilities that are fully accessible for walker & wheelchairs
- Nursing services: Insulin injections
- Intensive home-0based family therapy
- Family therapy that works primarily w/ adult caretakers
- University, college based programs that train family therapists
- Adequate psychiatric care for youth
- Sufficient salaries to retain experienced mental health providers
- Ongoing aftercare for people with mental health conditions that are permanent
- Strategies for integration into community/ whole and social activities
- Recovery trained clinicians / education programs
- Prevention activities, including self-help, skills training, youth mentors
- Consumer – run (true)
- Allow alternative self-directed options.
- Recovery training for clinicians & families
- Trauma informed services
- Self – Determined services
- Peer Support training is not sufficient
- Spirituality
- Holistic Opportunities
- Comprehensive team approach
- Transition from recovery

- Holistic – tradition medicines are not supported'
- Day tx for children
- Educational programs in schools in recovery
- Prevention activities
- Youth peer support training is not sufficient
- Day treatment
- Youth to youth support
- Statewide consisting in intensive in home services
- Respite
- FFT & DBT
- Lack of statewide consistency in parent support
- Warm line (consumer-run)
- Outreach to isolated populations
- Homeless
- GA coverage for mental health
- Transitional group homes
- Internet access to get information
- Access to respite care
- Warm lines
- Housing – Transitional housing- specialized work release programs / group homes
- Follow up programs-outreach programs for the homeless
- Parent partner/youth mentors
- More community based supported
- Serving the "whole" family holistically
- Employment / housing for children, youth & families
- Seamless transition from child serving to adult serving.
- Empowerment
- Looking at the positive
- Looking at the positive attitude off individuals
- Asking the individual what they need and what will work for them
- Lack of peer support
- More connection by services to school systems
- Adequate "matched key vocational services as in peer counseling
- Effective WRAP forms & training
- Warm line (consumer-run)
- Outreach to isolated populations
- Homeless
- GA coverage for mental health homes

4. WHAT ARE THE BARRIERS OR ACCESS ISSUES?

Table Notes:

- Eligibility Issues
- Cultural Issues

- Geographical Issues
- Not enough E&T's to decrease the number of people going into Jails
- Need to work with the criminal justice system toward diversion and best practice implementation
- Growing population of elders who are homeless this will increase demographically in the next few years.
- CSO offices turn away people who are mentally ill
- CSO offices turn away people who are homeless
- CSO offices insist on new psychiatrist evaluations even with massive documentation of mental illness
- Access to care standards encourage illness or overstating illness
- Jails who deny Access to inmates by Case managers or Ombuds
- Lack of discharge planning or mental health services upon discharge from the jails
- Reform Social Security administration, getting SS takes a minimum of two years.
- Eligibility too restrictive until crisis occurs.
- People are on and off coverage and medications – uncovered much of the time.
- Lack of Geriatric, Children's, Minority, Specialists
- Lack of coordination of healthcare with mental health care
- Dependence on Medicaid, no coverage for others
- Case managers are paid too low, so they don't stay in mental health
- Lack of public education and support to learn about mental health
- Stigma Acts as a barrier
- Lack of true integration between all systems (jail, schools, hospitals, foster care)
- Lack of Advocacy within systems of service delivery for specific populations needs
- Systems staff that are knowledgeable about assistance for clients who can't apply for SSI benefits and Medicaid
- Lack of staff who "look like" clients – reflect age, culture, race, ect.
- Lack of coordination of services
- Services not available in all counties
- Lack or choice and options within a resident county
- Choice in the system
- Limited funding
- Too high of caseloads
- No flexibility to access services
- Failure to implement grave disability criteria
- There should be no wrong doors, every professional should be able to access resources
- Access should not be limited by zip code
- Insurance can be a barrier to services
- 8-5 services creates limited access
- Lack of transportation
- System barriers to access
- Lack of collaboration and coordination
- Difficult to access services
- Lack of preventative care leads to crisis
- Too much paper work

- Lack of financial support to individual agencies
- Systems are cumbersome
- Lack of one permanent record from birth to death, the long look at what works, (group health does this on line and you can see your record)
- No universal health care limits access
- Transportation
- HIPAA and confidentiality prevents families involvement even when the client wants it
- Central 1-800 for all services
- Too many systems which aren't coordinated
- To many issues between agencies
- Involuntary treatment threshold is too hard
- Legal barriers and lack of interagency coordination
- Funding
- Access to care standards are too rigid and narrow
- Non-existence of affordable housing
- Transition from youth to adult services and eligibility requirements
- Paper work requirements are different for each agency
- Funding is impacted by diagnosis over lower diagnosis
- Inadequate number of beds for Medically Needy and DDD populations
- No people taking TBI, Autism, Aspergers, FAS
- Consumers lack information on how to access services
- Lack of awareness of learning issues
- Dangers of outreach
- Due to funding cuts when services are accessed there is not enough case management or therapy to meet the needs.
- Silos of Care – lack of integration
- No access to inpatient or sub-acute care for people with dual diagnosis or co-occurring medical or cognitive conditions
- Unless a person in crisis cannot access care in uninsured or not qualified for Medicaid
- An eligibility processes that is too complicated and time wasting for most people
- Homelessness
- Old technology at State level
- Housing and Crisis Beds
- Mind set- Deficiet based services, stigma
- Stable housing and living situations
- Access to treatment, treatment availability
- Reactions to "different" people, Stigma
- Lack of Service excellence
- Funding for client choices
- Funding for the system
- Funding Streams
- Eligibility
- Requiring someone to become sicker before treatment
- High caseloads
- Office based services
- Provider dropped tenant because they were using

- Lack of support in community for Mentally Ill offenders who leave prison
- Lack of preventative care
- Paperwork requirements
- Inability to build therapeutic relationships because of high staff turnover
- Inability to build trusting relationships
- Staff Turn over, salaries are too low, impacts quality of care
- Caseload size
- Involuntary care is too slow resulting in jail without care
- Limits of a tier system in some RSN's.
- More paperwork, lack of electronic records
- Enrolled with RSN resources are in a different RSN, creates placement problems
- Transportation – especially for family members of children
- Confidentiality as a barrier to coordinated care
- Facility issues (ADA kinds of access problems) related to placement options
- Staff at RSN's used to be providers and don't want to make any changes, just do things the way they have always been done
- No thought about how to benefit clients invest in new thinking
- Access to Care Standards
- Stigma, self stigma and system stigma
- Lack of Community and home based services
- Funding streams and payment mechanisms
- Complexity of systems and lack of information about where to call and how to get in.
- Wrong kids get MH services i.e. DDD.
- Lack of strategic direction at state level
- State agencies need to work together, DDD, DVR, CA, ADSA
- Transportation
- Affordable housing
- Liability issues, risk management issues
- Not enough access to get peer training certification
- Limited knowledge and training related to culture and language issues
- Lack of understanding of what recovery and resiliency mean
- Improve and separate peer training for adults, youth and parents
- Lack of information about available resources
- Professionals who are not knowledgeable resources
- Not having access easily enough
- Too much money to provide a "routine" instead of meeting needs
- Lack of coordinated care
- Not enough information is available to the general public about eligibility
- Need marketing

Summary Notes:

- Professionals who don't understand or appreciate the family or individual experience
- Information to the general public about emotional/mental health and individuals and families need specific information about how to access services and what services are available
- Lack of coordination of care
- Caseload sizes, low pay to line staff
- Transportation for support services or support people
- Administrative Burdens (Limited movement between RSN's, paperwork, doing things because we always have, complex system for consumers to negotiate, Tiers)
- High caseloads
- Services go to most symptomatic versus early intervention
- Stigma
- Access to treatment Lack of triage for crisis care
- Lack of preventive services
- Transportation
- DVR waiting list
- LRA's not enforced
- Silos – lack of coordination between MH providers and other systems of care
- Access to Care Standards
- Eligibility criteria are complicated and do not facilitate an easy or timely entrance into the system.
- Technology barriers – system outdated and inadequate
- Homelessness
- Lack of prescribers for Medicaid patients
- Lack of housing
- Lack of local community short term inpatient and diversion beds
- The Medicaid and state only eligibility process
- Stigma
- Access to care standards are narrow and rigid
- Funding
- Non-existence of safe affordable housing
- Lack of co-occurring services
- Lack of choice of providers in some RSN's
- Coordination issues among agencies (DDD/CD/MH)
- Eligibility for services until crisis
- Lack of expertise and services for specialized care, kids, adults, older adults, minorities ect.
- Lack of true integration of services across systems, jails, hospitals, long term care, schools, JRA, Foster care
- CSO- needs consumer advocates, disability workers at CSO's have no responsibility when errors result in no services.
- Access to care standards; need to overstate illness even if as a child results in services.

- Medical model really hurts the system, reliance on DSM and reliance on the disease model
- Lack of discharge planning when someone is being released from jail
- Make sure Ombudsman or case manager is assigned to jail to make sure financial eligibility isn't stopped and medications are received.
- Eligibility issues
- Cultural issues
- Geographic issues
- E&T's insufficient number available
- Growing population of elder homeless, will become a critical issue soon

Individual Questionnaires:

- Systems refuse to work together
- Eligibility criteria especially for FASD
- No understanding of services available – better understanding of services in MH community
- Geographic disparities
- Geographic
- Cultural
- Eligibility issues
- E&T's
- Denial of benefits due to beginning employment or hrs. or $.
- Cultural competency of all agencies/systems
- Language- the impact of politically incorrect verbiage
- CSO office workers over whelmed or lack compassion
- Access to care standards especially for children's type B diagnosis
- Defenders on Medicaid funding-to many
- Integration of services
- Lack of staff advocacy
- Finances
- Public services educational announcements
- Co-occurring problems are very prevalent
- High case loads!!!!!! Low salaries
- Admin, requirements (especially Federal & State requirements)
- Transportation (rural areas)
- Language/Cultural accessibility is a problem for many cultural groups
- Medicaid funding for non-Medicaid eligible people
- Public perception of mental illness & awareness of services is low.
- Inadequate funding for developing adequate housing stock
- Systems are siloed
- Funding is categorical
- Appropriate housing is NOT available
- Prohibitions and restrictions to access

- Clarifying roles & responsibilities of various system providers: determining the gaps: then filling the gaps
- Silos within the system (have to go through multiple agencies to get access for complex cases
- Lack of integration of services
- Lack of access for the non-seriously mentally ill people
- Persons with complex cases may not fit well in current system
- People moving frequently & lose services or they are homeless
- Lack of integrated technology systems at DSHS
- Silo's
- Better access to care before patient is in crisis
- Housing
- Too little follow-up after discharge
- Transportation
- Lack of communication, understanding & even awareness
- Services not available
- Finding streams-Eligibility (financial) cut offs have to decompensate or become sicker to get treatment – once you get well enough – don't always qualify
- The more involved in criminal justice system the less likely to have services
- Office based mental health services
- Medicaid model, appointment by basis
- Providers pressure to "drop" a person if "frequent no-show"
- High caseloads
- Too much redundant paperwork
- Staff turnover-clients having to repeat their story to a new case manager or other staff
- High staff turnover in community
- Mental health services creates a barrier to building trusting and effective therapeutic relationships between clients and providers
- Paper work!
- Authorization process—cannot start services
- Must determine medical necessity at first encounter
- Inability to build trust relationships
- Too much paperwork
- No computers to make the workload easier for case managers
- We need dialysis & wound care provided at ?
- Long wait lists- consumers not seen quickly
- No one wants to increase salaries even thought a lot of the services is given to the need today
- RSN may be resistant to balancing
- Focus on consumer with needs and perceptions of family & others who experience negative impact of consumers out of control behaviors
- Funding streams & payment mechanisms
- Lack of understanding of recovery
- Not enough access to training to get certified or peer councilors
- Not enough funding to support rates sufficient to do more recovery services
- DVR support for employment activities

- Peer support training insufficient
- Long term bureaucracy
- Stigma- Self stigma & system stigma
- Housing
- Transportation
- Complexity of SY---Lack of information
- Cultural / linguistic
- Access to care standards
- Funding streams & payments mechanism
- Access to Care standards for youth
- Self stigma
- Lack of community
- Funding streams
- Lack of info for the complexities of systems
- Cross system collaboration
- Transportation
- Housing
- Decline in MH beds
- Homeless people
- Incentives for sickest (services) diagnosis—where the get little to no "recovery" services
- Access to Care Standards
- Criminal history
- Transitional healthcare for people exiting GALL
- Back ground checks
- High turnover of clinicians
- Funding limitations-time based instead of progress forward
- Criminal History- History of assault-background checks
- Medicaid eligibility
- Lack of access to work release-other transition services
- Stigma – mentally ill offender
- Siloed funding
- Stigma / discrimination
- Co-occurring disorders
- Lack of information, youth & families.
- Care coordination
- Access to services
- Appropriate funding

OTHER COMMENTS:

- Grass roots organizations need to be funded, as they have been identified as most help for families and individuals w/ co-occurring multiple issues
- Eligibility
- Cultural

- Geographic
- Lack of “outrage” among constituents
- Challenges vary between urban & rural areas
- Incentives to serve most severely ill (sickest) and push less severe M.I. to primary care where they get little or no recovery services.
- High turnover of staff
- School & teachers need to be educated on how to work or ? with children with MH issues
- Peer training needs redesigned & made more effective
- Peer councilors
- Parents
- Youth
- Don’t be afraid to bring in “Spirituality into your conversations
- Always combine “recovery & resiliency
- Inclusive of youth and adults
- Continuum of services that do not compete with health, crisis, hospitalization, recovery –needs to be equal
- We need locked facilities for sex offenders so we can place them in the community
- We are required to place sex offenders from forensics at WSH & the Special Commitment Center into the community when they develop medical problems
- Affordable medications for limited income for non-Medicaid recipients
- By increasing provider capacity
- Need to also build the social support
- Capacity to assist in the navigation
- Understanding the holistic need of the consumer
- Need more diversion prevention, and intervention strategies implemented
- Lack of inter agency/inter jurisdictional agreement that are entered formally through MOU’s
- When individuals with MH issues apply for benefits they must have children to access services quickly or are coming out of jail or the hospital or are at risk for the hospital or jail
- How infuriating! Once on services / benefits if employment is obtained there needs to be a cushion before termination of benefits to help consumers to be successful
- Indiscriminate renew/termination of eligibility creates an on/off world of access
- Medications that by observation would show as system of detrimental service provision to consumers due to the time required adapting to being on/ off psychotic medications… this is dangerous!